MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

DOCUMENTATION IN PROGRESS NOTES

Effective Date: September 1, 2002 **Policy #: HI-05**

I. PURPOSE: To provide guidelines for the entry of progress notes into the patient record.

II. POLICY: Progress notes will be regularly entered into patient records in order to provide chronological documentation of the patient's clinical course. Procedures for entering progress notes will meet all requirements of state and federal statutes and regulations.

A. Progress notes are recorded by the clinical staff involved in active treatment modalities. Their frequency is determined by the condition of the patient, but notes are to be recorded at least weekly for the first eight weeks and at least once a month thereafter. The notes contain recommendations for revisions in the treatment plan as indicated and precise assessments of the patient's progress in accordance with the original or revised treatment plan.

The following are examples of the type of information to be entered into progress notes:

1. Documentation that the patient's treatment plan has been implemented;

2. Documentation of all treatment rendered to the patient;

3. Information that describes the patient's response to treatment and the outcome of treatment;

4. Any observation or information that could form a basis for altering the patient's course of treatment;

5. Documentation of the rationale for changes in medications or adjustments of dosages; and

6. Any unusual or significant events, incidents, or circumstances that affect the patient or their course of treatment.

B. All progress note entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed.

C. Staff will be trained in standard documentation practices. These include the following general format.

Description (e.g., subjective and objective information; observations; statements made by the patient)

Assessment (conclusions based on observation or patient's statements)

Plan (proposed interventions to resolve the problem)

D. Rules for proper entry of information into the medical record must be observed.

III. DEFINITIONS:

Progress Note – component of a patients' clinical record maintained chronologically and containing documentation of treatment provided to the patient, the patient's response to treatment, significant events, and other information pertinent to the patient's clinical course.

IV. RESPONSIBILITIES:

A. Clinical Staff *[including psychiatric technicians, licensed nursing staff, social workers, psychologists, chemical dependency counselors, rehabilitation therapists and teachers, rehabilitation therapy aides, chaplains, dieticians, and team leaders]* – to make progress note entries regarding their respective fields of expertise that accurately reflect all treatment provided to a patient, the patient's response to treatment, changes in the treatment plan, discharge plans, and significant events occurring during the course of hospitalization as applicable.

B. Physicians and Advanced Practice Nurse Specialists– to make progress note entries accurately reflecting all treatment provided to a patient, the patient's response to treatment, changes in the treatment plan, discharge plans, and significant events occurring during the course of hospitalization. In addition, physicians and Advanced Practice Nurse Specialists must enter documentation in the clinical record that provides the rationale for each prescription ordered, an evaluation of the patient's response to medication, and the rationale for medication changes.

V. PROCEDURE:

A. All staff members will record progress notes on the "Progress Notes" form in the patient's chart.

B. Psychology Staff will record progress notes on "Psychological Progress Notes". Notes not pertaining to Psychological Services will be recorded on "Progress Notes" form.

C. Rehabilitation Therapy Staff will record progress notes on green "Activity Therapy Attendance & Progress" forms. Notes not pertaining to Rehabilitation Therapy Services will be recorded on "Progress Notes" form.

D. Physicians and Advance Practice Nurse Specialists working in the Medical Clinic will document findings and recommended treatment on the **Physician Notes** located in the consults section of the medical record.

E. All requirements set forth in Montana Statutes (53-21-162 and 53-21-165, M.C.A.) relating to documentation and charting must be followed. These requirements include:

1. A summary of each significant contact by a professional person with the patient;
2. Documentation of the implementation of the treatment plan;
3. Documentation of all treatment provided to the patient;
4. Chronological documentation of the patient's clinical course;
5. Descriptions of any changes in the patient's condition;
6. A detailed summary of any extraordinary incident in the facility involving the patient, to be entered by a staff member noting that the staff member has personal knowledge of the incident or specifying any other source of information. The summary of the incident must be initialed within 24 hours by a professional person.
7. A summary by the professional person in charge of the facility or by an appointed agent of the determination made after the thirty (30) day review provided for in 53-21-163 M.C.A.

F. As a guideline, progress notes should be made immediately after a treatment or rehabilitation service is delivered and include

1. Identification of the service provided;
2. Length of the session;
3. A description of the patient's response to the service, including behavior and/or verbal statements;
4. An assessment of the patient's progress, lack of progress, and/or needs; and
5. Plans or strategies for the delivery of further therapy or rehabilitation services.
6. Physicians and Advance Practice Nurse Specialists need to document the rationale for orders written including lab work, medications, and treatments.

When it is not practical to make an entry each time a treatment or rehabilitation services is delivered, information about a series of treatment services may be summarized into a single progress note. Such a note should include an identification of the service provided; a listing of the dates that the service was delivered; a summary of the patient's response to the service, including and/or

verbal statements; an assessment of the patient's progress, lack of progress, and/or needs; and the plan for the delivery of future therapy or rehabilitation services.

G. When making a notation of an unusual or noteworthy event in the progress notes, the following information should be recorded:

1. A description of the incident;
2. An assessment of whether the event represents a significant departure from the patient's typical behavior;
3. An assessment, if possible of the reason for the event's occurrence;
4. Staff response;
5. Recommendations for future action to be taken (e.g., interventions to be used; changes to the patient's treatment plan or changes in medication; alterations to the patient's environment); and
6. Clear reference to the date and time that the incident occurred.

H. Specific components of the patient's treatment plan should be referenced when writing progress notes. This helps demonstrate the correlation between the progress note entry and the patient's treatment plan.

VI. REFERENCES: JCAHO – IM.7.2; State Statute 53-21-162 and 165 M.C.A.; and HCFA 482.61(c)

VII. COLLABORATED WITH: Director of Information Resources; Director of Quality Improvement; Director of Nursing Services; and Medical Director

VIII. RESCISSIONS: #HI-05, *Documentation in Progress Notes* dated March 14, 2001; HOPP #HI-05, *Documentation in Progress Notes* issued February 14, 2000.

IX. DISTRIBUTION: All hospital policy manuals

X. REVIEW AND REISSUE DATE: September 2005

XI. FOLLOW-UP RESPONSIBILITY: Director of Information Resources

XII. ATTACHMENTS: None

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Ed Amberg Date	Thomas Gray, MD Date
Hospital Administrator	Medical Director